PRINTED: 11/22/2018 FORM APPROVED OMB-NO: 0938-0391

CENTER	KS FOR MEDICARE	& MEDICAID SERVICES		and warming a committee		OMB NO. 0938-0391
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F 167	conducted 11/15/16 complaints were in required for complithe Federal Long T Life Safety Code so The census in this at the time of the sconsisted of four conference (Residents # 1 throreview (Resident # 483.10(g)(1) RIGH READILY ACCESS A resident has the the most recent sur Federal or State-sur Federal or State-sur required for the sur recent sur Federal or State-sur required for the sur recent sur Federal or State-sur required for the sur recent sur Federal or State-sur required for the sur recent sur	Medicare standard survey was 6 through 11/17/16. No vestigated. Corrections are ance with 42 CFR Part 483, form Care requirements. The urvey/report will follow. 17 certified bed facility was 10 urvey. The survey sample urrent Resident reviews ugh 4) and one closed record 5). T TO SURVEY RESULTS -	F	2	F 167 Right to survey results 1) After the surveyor reported on were not easily identifiable, a I Font) was added to the bulletin identify the location of survey results were accessible, however, there was that they were the results. 2) All ten residents on the unit may not having a posted notice indimost recent survey results. Accorrected the day the deficiency note, all residents are given a padmission which contains the ficopy of the most recent Long T is posted on the bulletin board station".	arge bold notice (72 in board on 11/16/16 to esults. Of note, the reposted and is not a notice indicating by have been affected by cating the location of the is mentioned, this was by was pointed out. Of packet of information on collowing statement- "A ferm Care survey results"
	examination and maccessible to resid their availability. This REQUIREMENT by: Based on observatifacility staff failed to recent survey result	ake the results available for ust post in a place readily lents and must post a notice of VT is not met as evidenced lions and staff interview, the post the location of the most is, and falled to clearly identify were found posted on a bulletin			All residents upon admission we the admission packet identifying survey results. Additionally, the were placed in a notebook labe Results" and attached to bullet in new dry erase board has been publicly displayed across from the 12/9/16. This dry erase board is bottom that states "The results survey conducted by Federal or any plan of correction is available beside this notice".	g the location of the e 2016 survey results led "State Survey n board on 11/29/16. A ordered and will be he nurse's station by has a notice at the of the most recent
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ABOBATORY	DIFECTORS GRAPROVID	ERSUPPLIER REPRESENTATIVE'S SIGN	ATURE	17		(88).DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

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F 167	facility at 2:45 p.m. papers was found to across from the Nuthe papers was a concept to be partment of Heat accompanying papersurvey results. The bulletin board to ide results, and there were papers of the papers	ge 1 Observations tour of the on 11/16/16, a sheaf of acked to a bulletin board rises Station. The top page of over letter from the Virginia lith indicating that the ers were the most recent are was no signage on the intify the papers as the survey results without reading the	F 167	4)	Starting 12/5/2016 the charge nuesure the most recent results a appropriate location under the appulletin board. She will initial on the results are posted. This check 45 days and will be monitored we nursing or his designee to ensure director of nursing will be responsiplan of correction from the 2016 approved by the Virginia Department.	re posted in the oppropriate sign on the a daily checklist that exhist will continue for eachly by the director of a compliance. The sible for posting the survey results, once nent of Health.
	vicinity of the Nurse on the nursing unit, and location of the to The survey results, location, were discubirector and the suit 4:20 p.m. on 11/16/483.25 PROVIDE CONGREST WELL But Each resident must provide the necessary maintain the high mental, and psychological accordance with the and plan of care. This REQUIREMENT.	ARE/SERVICES FOR EING receive and the facility must ary care and services to attain est practicable physical, social well-being, in a comprehensive assessment IT is not met as evidenced view and clinical record	F 309	ph 1)	Nursing staff was made aware of on 11/17/16 with further follow-up meetings. Resident #1 had no ad deficient practice as he continued and ambulating up to 500 feet. Nine residents had received pain could have been affected by the could have been affected by the could have educated on providing not interventions as part of the nursing director of nursing is working with department to edit the pain assess documentation of non-pharmacold more accessible. This edit will be	the deficient practice oplanned at staff diverse effect from it to be awake, alert medications and deficient practice. er 29 & 30, 2016, on-pharmacologic g care plan. The information systems sment to make agic interventions

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	F 309	non-pharmacologic	al interventions to address of ten residents in the survey	F 3	9 4)	Beginning December 26, 2016, the or his designee will audit ten reside for two months confirming that non	ent charts per month

Resident #1 was administered Ultram or Tylenol 17 times during the dates of 10/17/2016 through 11/15/2016 for complaints of pain. Use of non-pharmacologic interventions was implemented only three (3) times according to documentation in the EMR (electronic medical record).

Findings included:

Resident #1 was admitted to the facility on 10/17/2016 with diagnoses including, but not limited to: Pancreatitis, Malnutrition, Hypoalbuminemia, Placement of a PEG tube (feeding tube), Diabetes and Congestive Heart Failure.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 10/24/2016. Resident #1 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #1's electronic medical record was reviewed on 11/15/2016 at approximately 12:00 p.m. Documentation in the record included where this resident had received Ultram 25mg (milligrams) by mouth a total of six times and had received Tylenol 650mg by mouth a total of eleven times for various complaints of pain since his admission on 10/17/2016.

Subsequent review of Resident #1's CCP (comprehensive care plan) included a plan for pain with interventions that included,

interventions have been implemented and documented. If non-compliance is noted, an additional month of ten resident chart audits will be conducted.

Correction date: December 23, 2016

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... "non-pharmacological interventions..."

The DON (director of nursing) was interviewed at 3:45 p.m. regarding non-pharmacological interventions and where this would be documented in the EMR. The DON stated, "Let me research a little bit and see what information you all have access to in the medical record.

The DON approached the conference room on 11/16/2016 at approximately 9:30 a.m. with a paper copy of what the nurse's see in the EMR when documenting pain and interventions. The DON stated, "This is what the nurses see when they document pain. It has an area here for 'Pain' Alleviating Treatment Provided' with nine treatments listed that can be checked if used. It doesn't show up on your side unless you click on the time when a pain assessment was completed." This surveyor observed 17 pain assessments with interventions listed, only three assessments included non-pharmacological interventions.

The DON was advised of the above information during a meeting with the survey team on 11/16/2016 at 4:20 p.m. No further information was received by the survey team prior to the exit conference on 11/17/2016.

F 314 483,25(c) TREATMENT/SVCS TO SS=0 PREVENT/HEAL PRESSURE SORES

> Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores. does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having

F 309

F 314 Treatment/Svcs to prevent/heal pressure sores (sanitary manner)

- Nursing staff was notified of the deficient practice F 314 on 11/17/16 with further follow-up planned at staff meetings. Resident #1 was observed for signs and symptoms of infection related to the deficient practice during the dressing change. Resident #1 has not developed any signs or symptoms of infection.
 - There were no other residents on the skilled nursing unit who may have been affected by the deficient practice.

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F 314		elves necessary treatment and healing, prevent infection and		3) After referencing Clinical Nu Techniques (Potter & Perry, 2014), a provide guidelines on clean dressing of staff were educated on this policy on N 2016. The steps of this policy include	policy was written to changes. Nursing November 29 & 30,

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview and facility document review, facility staff failed to treat a pressure ulcer in a sanifary manner for one of 10 residents in the survey sample, Resident #1.

RN #3 (registered nurse) failed to use proper hand hygiene, set up a clean working field, opened sterile dressing packages and placed onto an unclean working field, performed a clean dressing change with contaminated gloves and dressing supplies, and returned multi-use dressing change supplies back to the night stand white wearing contaminated gloves during a dressing change to a sacral pressure ulcer on Resident #10.

Findings included:

Resident #1 was admitted to the facility on 10/17/2016 with diagnoses including, but not limited to: Pancreatitis, Malnutrition, Hypoalbuminemia, Placement of a PEG tube (feeding tube), Diabetes and Congestive Heart Failure.

The most recent MDS (minimum data set) was an initial assessment with an ARD (assessment reference date) of 10/24/2016. Resident #1 was assessed as cognitively intact with a total cognitive score of 13 out of 15.

Resident #1's electronic medical record was

- Assemble needed supplies at bedside. Close room door or bedside curtains.
- b. Perform hand hygiene and apply gloves.
- Open sterile packages and topical solution containers.
- d. Remove bed linen and patient's gown to expose area to be treated.
- e. Remove old dressing and discard.
- f. Remove gloves and perform hand hygiene. Apply clean gloves.
- g. Cleanse wound thoroughly as prescribed.
- h. Apply topical agents if prescribed.
- i. Using a sterile cotton tipped applicator, apply a small amount of topical agent to the wound. Do not re-use soiled cotton tipped applicator for other areas of the wound or insert soiled applicator into any container.
- i. Apply dressing as prescribed.
- i. Position patient for comfort.
- k. Remove gloves and perform hand hygiene.
- 4) Starting December 5, 2016, the director of nursing or his designee will observe three pressure sore dressing changes each week, if any are present on the unit, until a total of fifteen dressing changes have been observed. If compliance with clean dressing change is not maintained after fifteen dressing changes, another round of three per week will be observed for another total of fifteen.

 Compliance with proper clean dressing change technique will be reported monthly at staff meetings and quarterly at

will be reported monthly at staff meetings and quarterly at the unit performance improvement committee beginning January 2017.

Reference: Potter, Patricia. A. and Perry, Anne. Clinical Nursing Skills & Techniques. 8th edition. St. Louis: Mosby, Inc. 2014. Correction date: November 30, 2016

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		2016 at approximately 12:00	F .	J 14		
	p.m. Physician ord	ers included specific wound				
	care orders. Wound	care documentation included				
	care of a sacral pressure ulcer.					
	surveyor spoke with #1's pressure ulcer, when I changed his so I left it open to at area looks now. La RN #3, this surveyo surveyor entered Rt #1's room. RN #3 is were in the room and himself in the bed o donned a pair of cle Resident #1's sacra red in the midline ar Three open areas who buttock and two on stated, "It has opened ressing change sturn #3 covered the retrieved dressing change sturn #4 covered the retrieved dressing change sturn #4 covered the retrieved dressing change of 4x4's,	pproximately 3:40 p.m. this in RN #3 regarding Resident. RN #3 stated, "Last night dressing the area was heated in. We can go assess how the stinight if was all dried up." In and a federal oversight esident informed Resident #1 why ad the resident repositioned into his right side. RN #3 is an gloves and exposed larea. The sacral area was not out onto both buttocks, were noted, one on the left the right buttock. RN #3 and up again, so let me get his aff and I will cover it back up." exposed area while she hange supplies from Resident he opposite side of the bed. It is of dermal wound cleanser, a skin prep package, and it abox with a tube of				
	lodosorb ointment. to the medication ca	She went out into the hallway art and obtained two packages				
		bs and returned to the ced all the wound care				
		ceo an the wound care ant #1's bedside table. She				
	did not clean the her	iside table or place a clean				and the same of th
		RN #3 opened the Allevyn				0000000
		lifway out of the package and				ренилованую

placed it on the bedside table. She took the lodosorb tube out of the box, removed the lid and

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F 314	placed onto the ber package of sterile 4 dermal wound clear resident, exposed I reddened areas will on the 4x4's, discal trash can, removed squeezed lodosorb applied lodosorb of using the same cot swab, opened a se of of the first of the lipulation of the same cot swab, opened a se of the first of the lipulation of the same cot swab, opened a se of the first of the lipulation of the outer edges of removed the Allevy removed the Allevy removed the cover dressing over Residuals assisted Resident if with pillows behind knees, then covered linens. She gather supplies from the back into the drawetime RN #3 removed donned at the start used hand sanitized washing her hands the entire wound as procedure. The DON (director the above observat survey team on 11/surveyor requested	riside table. She opened the ix4's and wet them with onser. She then turned to the his sacral area, patted the in the dermal wound cleanser ded the 4x4's in the bedside on a sterile cotton swab and continent onto the tip. RN #3 intment to all three open areas for swab, discarded the first cond swab, applied lodosorb of the second swab and owest open area on the right os were discarded into the RN #3 applied skin prep to Resident #1's sacral area, in dressing from its package, and placed the Allevyn dent #1's sacral area. RN #3 #1 to remain on his right side his back and one between his dithe resident with his bedied all the dressing change edside table and placed them er of the nightstand. At that ed the pair of gloves she of the wound observation and it. RN #3 was never observed or using hand sanitizer during seessment or dressing change of nursing) was informed of ion during a meeting with the 16/2016 at 4:20 p.m. This any facility policies pertaining hange techniques during the	F	314			

meeting.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	surveyor a "Hand H Revised 2/02; Revie used by the facility i techniques from "Cl Techniques" by "Po stated, "We use Poi standard for dressin The "Hand Hygiene "1. Purpose: Your I vehicle in almost ev pathogens 2. Polit cleansed routinely: the patient; Betweer after handling conta with inanimate object equipment) in the im patient After conta skin; before donnir "Potter and Perry" si Pressure Ulcers" pa " 2. Assemble sup hand hygiene and as sterile packages and Keep dressings steri arrange patient's gos surrounding skin 5, discard in appropriat gloves and discard, and change gloves, with normal saline or agent from least con contaminated area, wound using cotton-las ordered 9. Apply dressing 10. Repos	200 a.m. the DON brought this ygiene Policy Issued 11/95; ewed 8/13" and a reference for clean dressing change linical Nursing Skills & tier and Perry." The DON Iter and Perry. The nursing no changes." Policy" included the following: hands serve as the common ery transfer of potential cy. Hands should be Before having contact with a every patient contact and minated articles; After contact cits (including medical imediate vicinity of the net with a patient's intacting gloves" Iteps for "Treatment of ge 449 included the following: plies at bedside3. Perform poly clean gloves. Open it topical solution containers. Ite4. Remove bed linen and win to expose ulcer and Remove old dressing and the receptacleRemove 6. Perform hand hygiene 7. Clean wound thoroughly prescribed wound-cleansing taminated to most 8. Apply topical agents to dipped applicators or gauze by prescribed wound sition patient comfortably off	F	314			
	pressure uiter. 11.	Remove gloves and dispose					addumnéčna systycy

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F 356	Continued From pa staffing data for a n required by State la	ge 9 ninimum of 18 months, or as w, whichever is greater.	F 3	56	d. e.	Total number of RN, LPN, an resident care Current number of residents.	. •
	by: Based on observatifacility failed to positive Skilled Nursing Unitacility, current date worked, and the current of the findings were: During the General p.m. on 11/16/16, if the nursing unit to a members, and generallity, the current cand certified staff (Feractical Nurses and Assistants) working	Observations four at 2:45 here was no signage found on idvise residents, family eral public of the name of the late, the number of licensed Registered Nurses, Licensed		4)	shift the this days	rting 12/9/16 the charge nurse that the current information is dry erase board. She will initial was completed. This checklists and will be monitored weekly sing or his designee. rection date: December 9, 20	publicly posted on on a checklist that t will continue for 45 by the director of
	discussed with the street the survey team during 11/16/16. 483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro considered satisfact authorities; and	m sources approved or ory by Federal; State or local	F 3.	7 °¢			

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F 371 Continued From	page 10	in the same of the	371	Food Storage Policy	Moder-viral rest for inclusive form through rest like completure viral purer against A ₂ propriégated po

This REQUIREMENT is not met as evidenced. DV.

Based on observations, staff interview, and review of facility documents, the facility staff failed to store, prepare and serve food in a sanitary manner in the main kitchen and in a small kitchen on the Skilled Nursing Unit.

A tour of the Main Kitchen and the Nursing Unit Kitchen found expired dairy items, open, undated and uncovered food items in the dry storage room, walk-in coolers and freezer; food at an incorrect temperature on the food line; personal items, including a prescription medication stored behind a coffee maker: no test strips available for both three compartment sinks; a dirty can opener: a lack of sanitation during the test of food temperatures; a food service employee without a beard guard.

The findings were:

1. The initial tour of the main Kitchen was conducted beginning at approximately 10:45 a.m. on 11/15/16. The surveyor was accompanied by the Director of Food Services during the tour and the following observations were made:

A. Catering Area immediately adjacent to the Main Kitchen:

At the three compartment sink, the surveyor asked if there were any test strips for checking the chemical sanitization levels used during the wash, rinse and sanitization process, "We did

Food Storage Policy was reviewed, revised to include a daily audit tool for checking to ensure all opened bulk packages and refrigerated foods are appropriately labeled and dated "for use by" per policy. Completed 11/18/2016

Felt tip markers and stick on labels added to the kitchen prep areas so staff will have supplies available to complete the labeling and dating process. All nutritional service staff educated on process and expectation for relabeling and dating of all opened bulk food packages. Completed 11/27/2016 Nutrition Services Management staff assigned to conduct daily auditing and follow-up with immediate corrective action if compliance is not found. Implemented 11/28/2016

All Nutritional Service staff reeducated on performance expectations to secure and cover all open food items. Completed 11/27,2016

Nutritional Services Management Staff assigned to conduct daily auditing to verify all opened items are properly secured and covered-follow-up with immediate corrective action if compliance is not found. Implemented 11/28/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 3/ 1	Continued From pa		F	371	Engineering installed small		
		s)," the Director of Food ybe they fell. Maybe someone			wall mounted container above		
	took them to the Ki	chen." The Director of Food			sinks to provide easy access		
	Services went on to	explain that although the			and storage of sanitizer test		
		sinks are used, anything			strips. Completed 11/28/2016		
		is taken and run through the e we should be checking the					
	water."	in same managers of party and spread said the			 Staff reeducated on proper 		
					use of the test strips and		
	On a stainless stee	I table in the Catering area. I tulation of dried, black debris			performance expectations.		
		le mounted can opener.			Completed 11/28/2016		
	On a stainless stee compartment sink valong with a large, obehind the coffee mpersonal items, including soda cup, a diplastic container, air prescription medicinobearing the name of Director of Food Secatering area. (NOTE Erythromy the treatment of mill skin and soft tissue	I table next to the three was a large coffee maker circular urn for tea. Stored haker were an number of uding a pair of black gloves, a ozen brown eggs in a clear			 Management staff will verify and document on daily log that test strips are available during daily rounding activities. Implemented 11/29/2016 All staff have personal lockers and were reeducated they are to utilize them for all personal belongings. Completed 11/28/2016 Management staff will verify and document on the daily log 		
	as Nutrition Assistar appeared on the En	16/16, the employee, identified nt # 2 (NA # 2), whose name ythromycin label, was where she works, NA # 2			that no personal belongings are stored in the work areas during daily rounding		

said she primarily works in the dining and

catering areas. When asked if the Erythromycin belonged to her, NA # 2 said, "Yes. I have psoriasis. My doctor thinks it is related to my

activities. Implemented

11/29/2016

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		About Alexandra	eliclina sek	FISHERSVILLE, VA 22939	
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pregnancy and she is trying the Erythromycin to treat it." NA # 2 went on to say that the facility and the Food Services Director were aware of her condition.

Asked about the other items behind the coffee maker, NA # 2 said she didn't know who the gloves belonged to, but that the eggs belonged to another employee who brought them in to sell. Regarding the soda cup, NA # 2 said, "We aren't allowed to have them (drinks) on the floor (food preparation area), so we keep them there."

At approximately 8:00 a.m. on 11/16/16, the Food Services Director was interviewed regarding NA#2's skin condition. The Food Services Director said he was aware of her condition, that she had been seen by the hospital's Employee Health Department, and cleared to work in her current capacity.

B. Main Kitchen area:

In the Dry Storage area, the following items were open and undated; a small bag of Trail Mix that had been repackaged by the kitchen staff, a bulk bag of Trail Mix, a bag of Whole Grain Elbow Macaroni, a bag of Corn Bread Mix.

in the first of two walk-in coolers, a container of cooked chicken was not tightly sealed. As soon as the Food Services Director touched the lid to check the date, the lid popped off.

In a walk-in freezer, there were two open bags of frozen raspberries. One bag was not dated, and the other bag, which was lobsely wrapped, had a date that was not legible. Base of can opener was cleaned of all debris. Completed 11/15/2016

Staff reeducated on the performance expectations for the cleaning of items on the daily cleaning list. Completed 11/28/2016

Verification of cleanliness of the can openers, including the base were added to the manager's daily log. Completed 11/29/2016

Employees who wish to maintain facial hair, regardless of close grooming and short length are educated on requirement to wear a beard guard while working. Failure to do so can result in corrective action.

Completed 11/18/2016

Department Director will ensure sufficient supplies of beard guards are available in the department at all times. Completed 11/18/2016

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Continued From page 13

In the second walk-in cooler, there were three crates, partially filled with half pint cartons of milk. All the cartons of milk had an expiration date of 11/12/16. The crates of expired milk were adjacent to crates of milk, also half pint cartons. that were not expired and that were in use. There was no signage on the expired milk crates to indicate the milk was not to be used. "Those are set aside to return to the vendor for credit," the Food Services Director said.

Also in the cooler was a small bag of cubed, white potatoes that was not dated; and a small, rectangular can labeled "Roasted Garlic" that was not covered or dated. There was also a rectangular pan labeled "Tomato Paste" that was covered and dated 11/13 - 4/13. Asked what 11/13 - 4/13 meant, the Food Services Director said, "I don't know."

During the tour, the surveyor and the Food Services Director passed by the food service line. The Food Services Director volunteered to check the temperatures of the food on the line. Of the approximately 15 food items checked, only the macaroni and cheese at 132 degrees failed to reach the appropriate temperature. The macaroni and cheese was taken off the line.

Prior to checking the food temperatures, the Food Services Director obtained an antiseptic wipe with which to clean the probe on the thermometer. After checking the temperature of approximately six or seven food items using the same wipe, the Food Services Director obtained another wice which he used to clean the thermometer probe as he checked the rest of the food temperatures.

While the food temperatures were being

performance expectations to maintain correct storage location for out of date dairy products: failure to comply will result in corrective action. Completed 11/28/2016.

> Large DO NOT USE /EXPIRED signage securely attached to the milk crate used for of out of date dairy products (which are returned to vendor for credit). Completed 11/18/2016.

Management staff verifies DO NOT USE /EXPIRED sign is attached and crate is appropriately located in cooler (separate from current stock), verification of compliance is documented in manager's daily log. Implemented 11/18/2016

Out of temperature items on the hot service line: Previous process was to record temperatures every 4 hours. If product was out of temperature it was discarded and replaced.

The process revised to check and record temperatures every two hours. If an item is out of temperature it will be reheated to 165 degrees for at least 15 seconds and returned to the line.

Staff trained on this new procedure and process implemented. Correction date 11/29/2016

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	checked, a food se plating food to be s	rvice employee was observed erved. The employee, who was not wearing a beard					
	C. Dish Washer Room;						
	A second three compartment sink was found in the Dish Washer Room. Asked if there were any test strips, the Food Services Director said there were none:						
	D. Following the tour of the Kitchen, the requested and received the facility's pol- food storage and personal hygiene.						
	Review of the "Foo 6/24/16, noted the i	d Storage" policy, dated following:					
	wrapped or covered e. Any outdated pe following the guideli policy. All outdated pickup and credit w container away from	e labeled, dated, and securely					
	Frozen Storage b. All food items an wrapped or covered	e labeled, dated, and securely					and the second s
		tion Services Infection Control 16, noted the following:					Resid vanishir Hespitaleoloogusooso
	"Procedures						emana de la companya

1 Personal Hygiene:

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c. The hair mustor hair net. Bear 1/2 inch long. 5. Food Storaged. Any outdated Outdated Milk makept in a separa marked 'DO NO PRODUCT.' It should be not requiring a bear long is in direct. Regulations white under subsection employees shall hats, hair covering the food regulations, Pater Effectiveness of 2. Beginning at 11/16/16, a Genousing unit, Kitchand the following A. Nursing Unit. The refrigerator uniopened cartor Drink with a use of Silk Soy Milk in the storage of the second silk Soy Milk in	t be restrained with either a cap rd nets required for beards over a perishables will be discarded, as be retained for pick up but the area with labeled container T USE - OUTDATED In that the facility's policy of the for beards over 1/2 inches conflict with the Virginia Food can be of this section, food wear hair restraints, such as a new and the food that the facility is policy of the food that the facility's policy of the section, food wear hair restraints, such as a new and the food that the facility is policy of the facility of the					

At the three compartment sink area the Patient Services Manager for food services was asked

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F 371	said there were no really don't use the everything to the di- Behind the coffee into the three compa- drink cup and a car the coffee maker wholding what appear and a container had, doesn't need to be C. Main Kitchen ar The small, rectange Garlic" observed or walk-in cooler, not of the food service er on 11/15/16 was observed. The employence wearing a beard. D. Dish Washer Row, the was asked about the Services Manager in the sink area, but he a drawer in a table of Room.	he Patient Services Manager test strips and added that "We sinks that way. We send sh washer." maker located on the table next riment sink there was a soft ton of Silk Milk. Also behind as a clear plastic container ared to be personal items. Na he surveyor at the time said 'Random things. Stuff that behind there." ea: alar pan labeled "Roasted in 11/15/16, was still in the covered or dated. mployee observed plating food served in the food preparation e, who had a short beard, was i guard. com: compartment sink in the Dish Patient Services Manager st strips. The Patient ndicated there were none at a was able to obtain one from adjacent to the Dish Washer	F	371				
	activated the chemi-	s Manager took the test strip, cal feed system, and held the sanitization chemical feed					Polit-Modelle allice and consequence	

line. After about 30 seconds the Patient Services

Not bear that is done in	AND A PARK AND	TAPE TO FRANCISCO TO SALE TO SALE TO SEE THE STAND SALE	and the second s		CONTROL OF THE PROPERTY OF THE
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F 372	showed the strip to the strip reflected sanitization chemic diluted sanitization sanitization process. During a meeting where the sanitization of the sanitizat	the chemical flow and then the surveyor. The reading on traight concentration of the all and not a reading of the chemical used during the schemical used during the findings of the Kitchen and on tours was discussed. ISE GARBAGE & REFUSE spose of garbage and refuse of garbage and or maintain the dumpster area as free of debris. The main Kitchen, which was ag at approximately 10:45 a.m. and the Dumpster/Loading riveyor was accompanied by a Services during the tour. The sading Dock area, the Food adicated there were two cardboard and the other for		F372 Dispose of Garbage & Refuse The blue trash carts did not contain su Environmental Services Staff removed which had accumulated under the bas Correction date: Nevember 16, 2016 Environmental Services Staff reeducat expectations to routinely check for and including leaves, found under or arour containers in dumpster area. Complete Environmental Services Management monitoring of dumpster area to ensure Implemented 11/28/2016	rigical trash. If all leaves and debris e of the dumpster. If the dumpster is
	dumpsters, one for general waste. The				

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F 441 SS=D	around the metal be secured, there was and trash, including the dumpster accessory to the dumpster accessory to the dumpster accessory to the dumpster accessory to the findings were skilled Nursing dust team at 4:20 p.m. 483.65 INFECTION SPREAD, LINENS The facility must expressed to help prevent the of disease and infection Control P safe, sanitary and to help prevent the of disease and infection Control P safe, sanitary and to help prevent the of disease and infection Control The facility must expregram under which investigates, coin the facility,	en picked up. On the ground tase into which the dumpster is an accumulation of leaves g blue, latex gloves. g dock, immediately adjacent to iss, were two blue trash carts astic bags. The bags were ets and clear, plastic oxygen ood Services Director said the rigical trash. discussed with the Director of ring a meeting with the survey on 11/16/16. N CONTROL, PREVENT stablish and maintain an rogram designed to provide a comfortable environment and development and transmission action. of Program stablish an Infection Control ich it—	F 37	F 2 me Dro 1)	441 Infection control, prevent spred, hand hygiene) opped Medications The two residents involved with the medications were observed since noted and have not shown any signification. All ten residents on the unit potent affected by the deficient practice as signs or symptoms of infection. After referencing Clinical Nursing (Potter & Perry, 2014), a policy was guidelines for handling dropped medications. Perform hand hygiene prior to medications. b. When a medication is dropped.	the dropped the deficiency was gns or symptoms of tially could have been and none have shown Skills & Techniques as written to provide edications that is acated on this policy steps of this policy of administering
	should be applied to (3) Maintains a rec- actions related to in (b) Preventing Spre-	ead of Infection			gown, bed/chair linen or bedsi medication with clean hands for soiling. If none visible, the me administered.	de table inspect the or any visible
	(1) When the Infect determines that a re	tion Control Program esident needs isolation to of infection, the facility must		1	c. When a medication is dropped visibly soiled, the medication w	onto the floor or is vill be discarded

and a new dose obtained.

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Continued From page 19 isolate this resident.

- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct confact with residents or their food, if direct confact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on medication pass and pour observation, hand hygiene observation, staff interview and facility document review, facility staff failed to follow infection control practices on the skilled unit.

Facility staff failed to follow proper technique for dropped medications during the medication pass and pour observation and failed to perform proper hand hygiene during two separate observations.

Findings included:

A medication pass and pour observation was performed on 11/16/2016 at approximately 8:10 a.m. with LPN #1 (licensed practical nurse), this surveyor and a federal oversight surveyor.

During medication administration to the first resident a pill was dropped onto his gown. LPN Augusta Health has an incident reporting system in place for staff to report variance in practice. The director of nursing will monitor the medication variance report on an ongoing basis. Any variance related to a dropped medication will be addressed with the individual employee and reported at the unit performance improvement committee beginning in

Reference: Potter, Patricia. A. and Perry, Anne. Clinical Nursing Skills & Techniques. 8th edition. St. Louis: Mosby, Inc. 2014.

Hand Hyglene

January 2017.

- Nursing staff was notified of the deficient practice on 11/17/16 with further follow-up at staff meetings. No resident was affected by the deficient hand hygiene practice of RN#3 as this observation was at the end of a resident encounter.
- All ten residents potentially could be affected by deficient practice in hand hygiene. However, there have been zero nosocomial infections on the skilled nursing unit in the past three months.
- 3) The hand hygiene policy was reinforced with staff during staff meetings on November 29 & 30, 2016. Education included that alcohol hand rinse is the preferred method of hand cleansing except when hands are visibly soiled or with patients with c. diff. Also included in the education was reinforcement of fifteen seconds of hand washing when using soap and water and the use of paper towels to turn off faucets.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 11/22/2016

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391
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	placed back into the cup. The resident inot wearing gloves his pills. LPN #1 applied gloth this resident. After went into the resident water in the sink, wrubbed together for rinsed, turned off whands and dried will administration to a approximately 6:25 the resident's bedsipill up with a gloved pill to the resident. LPN #1 was intervisapproximately 10:3 #1 stated, "I usually in contact with bodi insulin, stuff like the sanitizer. Normally drops, insulin, clear use gloves when oppreak and a piece copen packets so I do pill on the floor or scone. If drops on the let them take it." The DON (director of 11/16/2016 at 1:30) is no specific policy meds are dropped.	on the resident's gown and the medication administration then took the pill. LPN #1 was during the administration of the seconds of the gloves LPN #1 ant's bathroom, turned on the removal of the gloves LPN #1 ant's bathroom, turned on the removal of the gloves LPN #1 ant's bathroom, turned on the removal of the part of the part of the seconds, water faucets with her bare, wat the paper towel. During pill		44 4)	To monitor compliance with har resident encounters spread acre be observed by hand hygiene a an ongoing basis. Compliance policy will be reported to the dire in monthly staff meetings and reperformance improvement compliance of the compliance of the compliance of the complex staff. Correction date: November 30 correction date: Novemb	oss all three shifts will auditors per month on with hand hygiene ector of nursing, shared eported to the unit mittee beginning in

what to do in case of med errors or missed

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	medications, "Actual scenario. If it dropp would probably returned dropped on their go would not get another.	his expectation for dropped ally would depend on the seed on the floor or table I sen it and get another one. If it swn or clothing I probably her one. Some patients have if I'd say it happens."					
	her hands after rem approximately 4 00 sensored sink. She	nurse) was observed washing noving gloves on 11/16/2016 at p.m. RN #3 used a motion a wet her hands, applied soap, ely five seconds, rinsed and oper towel.				1	
	washing observation meeting with the su approximately 4:20	med of the above hand ns by this surveyor during a rvey team on 11/16/2016 at p.m. This surveyor requested hand hygiene policy.					
	DON presented a convigiene policy to the Hygiene Policy Issue Reviewed 8/13" included thands serve as the every transfer of population to another	pproximately 8:00 a.m. the opy of the facility hand is surveyor. The "Hand led 11/95; Revised 2/02; luded, "1. Purpose: Your common vehicle in almost tential pathogens from one hand hygiene is the single asure for preventing the					

spread of infection...3. Procedure: Hand washing...B, Steps: 1, Wet hands with warm water and apply soap...2. Wash hands vigorously for FIFTEEN seconds...4. ...Avoid touching the sink and faucets with your hands...5. Rinse hands under running water...6. Pat hands and wrists dry with a paper towel. 7. Turn off the faucets and open door using a paper towel, to

avoid re-contaminating your hands..."

RS FOR MEDICAR	RE & MEDICAID SERVICES			OMB NO. 0938-039	
	(K1) PROVIDERSUPPLIERICLIA IDENTIFICATION NUMBER: 495214	The second secon		(XII) DATE SURVEY COMPLETED	
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Both the Nursing U	nit Kitchen ice machine and				
	PROVIDER OR SUPPLIE A MEDICAL CTR SI SUMMARY'S (EACH DEPICIEN REGULATORY OF Continued From (No further informate an prior to the 483.70(c)(2) ESS OPERATING COI The facility must rimechanical, elect equipment in safe This REQUIREMENT by, Based on observing facility failed to en produce ice for pathat produce ice f	AMEDICAL CTR SKILLED CA SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FILL REGULATORY OR LSC IDENTIFYING IMPORTATION) Continued From page 22 No further information was received by the survey team prior to the exit conference on 11/17/2016. 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by. Based on observations and staff interview, the facility failed to ensure two ice machines that produce ice for patient use, and one ice machine that produced loe for non-patient use had a drain system air gap. In the Laundry, a wall mounted circulating fan had an accumulation of lint. The findings were: During the General Observations tour at 2:30 p.m. on 11/16/17, the following was noted: 1. In the Nursing Unit Kitchen, a counter too ice	OF DEFICIENCIES OF DEFICIENCIES OF DEFICIENCY A MEDICAL CTR SKILLED CA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED AY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued Front page 22 No further information was received by the survey team prior to the exit conference on 11/17/2016. 483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility falled to ensure two ice machines that produce loe for patient use, and one ice machine that produced loe for non-patient use had a drain system air gap. In the Laundry, a wall mounted circulating fan had an accumulation of lint. The findings were: During the General Observations tour at 2:30 p.m. on 11/16/17, the following was noted: 1. In the Nursing Unit Kitchen, a counter top ice machine, located next to a hand washing sink, did not have an air gap. The drain line for the ice machine, located on the floor near a walk-in cooler, did not have an air gap. The drain line for the condensar unit, and the drain line for the ice holding bin were laying directly on top of the floor drain.	A BUILDING A BUILDING A BUILDING A BUILDING A BUILDING E WINS STREET ADDRESS, GITY, STATE, ZIP C TO MEDICAL CRT SKILLED CA BUILDING BUILD	

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F 456	patient use. 3. In the Laundry remachine, located or not have an air gap machine was connewashing sink out fit duly noted that the does not produce to 4. In the Laundry recirculating fan, locabins, had an accumscreen. The fan was observation. The findings were coskilled Nursing, the	oom, a counter top ice ext to a hand washing sink, did. The drain line for the ice exted directly to the hand ow line above the trap. It is ice machine in the Laundry	F	¥56		
